CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR LICENSED ASSOCIATE COUNSELOR OF MENTAL HEALTH

INSTRUCTION SHEET FOR APPLICANTS AND SUPERVISORS

Both applicant and supervisor(s) should carefully read this instruction sheet before completing and submitting the application. Failing to follow instructions may delay licensure. All auxiliary forms needed are included in this packet. If the application is not complete within six months of filing, it may be considered abandoned and discarded.

Important Information for Applicants and Supervisors: Written Plan for Professional Counseling Experience and Supervision

The purpose of the experience questions on this application is to document and verify how much acceptable post-Masters experience in actual *mental health counseling* the applicant has already completed. Once you know how much experience the applicant has completed and how much direct supervision he or she has received, you will know how much more experience and supervision the applicant needs to complete while an Associate Counselor of Mental Health so that he or she will later meet the requirements for Delaware licensure as a Professional Counselor of Mental Health. Those requirements are summarized below:

Professional Counselor of Mental Health
POST-MASTERS MENTAL HEALTH COUNSELING EXPERIENCE REQUIREMENTS

When applying for licensure by certification, you must arrange for the Board office to receive verification that you have provided the required hours of post-Masters mental health counseling. The following definitions apply to this requirement:

- Mental health counseling means face-to-face interaction with clients and other matters directly related to the treatment of clients in a professional mental health clinical counseling setting.
- Direct supervision means overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. Certified school counselors and certified school psychologists are not approved clinical supervisors.

For more information about the experience requirements, refer to Sections 2.1.3 and 2.1.4 of the Board's Rules and Regulations available at www.dpr.delaware.gov.

1. You are required to have provided a total of ***at least 1600 hours*** of ***post-Masters mental health counseling*** while under the ***direct supervision*** of one or more ***approved clinical supervisors***. When combined, the hours of supervision under all approved clinical supervisors must span a period of *at least two but not more than four years*.
   - When totaled, at least 100 of the 1600 hours of direct supervision under all approved clinical supervisors must be face-to-face sessions between you and your supervisor.
   - When totaled, at least 60 of the 100 hours of direct supervision under all approved clinical supervisors must be face-to-face one-on-one – that is, you and your supervisor. The remaining 40 may be in a group setting – that is, you, your supervisor, and up to five other supervisees.

2. Whether any further documentation of hours of post-Masters experience is required depends on whether you have completed 30 post-Masters credit hours in the field of counseling.

IF you have…	THEN…
completed 30 post-Masters credit hours in the counseling field	no further documentation of post-Masters experience is required other than an official transcript, sent directly from the school(s), showing that you have completed the credit hours.
not completed 30 post-Masters credit hours in the counseling field	your clinical or administrative supervisor(s) must verify that you have provided additional hours of post-Masters mental health counseling. These hours, when added to the 1600 or more hours of direct supervision verified by your clinical supervisor(s), must total at least 3200 hours.

The hours of experience and supervision that the applicant has not yet completed are documented on the **Written Plan for Professional Counseling Experience and Supervision.** To assure that both the applicant and the supervisor understand the plan, both must sign off on it.

When answering the experience questions on the application, it is important for both applicant and his or her supervisor(s) to understand the following:

- The hours of direct supervision that the applicant has already completed plus the planned hours of direct supervision (as documented in the **Written Plan**) must total at least the mandatory 1600 hours of direct supervision. In addition,
  - The applicant's completed hours of face-to-face sessions between applicant and supervisor plus the planned hours of face-to-face sessions must total at least 100 hours.
  - The applicant's completed hours of one-on-one sessions with the supervisor plus the planned hours of one-on-one sessions must total at least 60 hours.

- The hours of experience the applicant has already completed—whether or not under direct supervision of an approved clinical supervisor—added to the hours of experience in the **Written Plan** must total the required hours for licensure. In other words,
  - If the applicant does not have 30 post-Masters credit hours in the counseling field, ***all*** of the applicant's completed experience added to his or her planned experience must ***total at least 3200 hours***.
  - If the applicant has 30 post-Masters credit hours in the counseling field, ***all*** of the applicant's completed experience added to his or her planned experience must ***total at least 1600 hours***. In this case, all 1600 hours must be direct supervision hours.

- ***All*** **of the required hours—completed plus planned, whether or not directly supervised—must span a period of not less than two but no more than four years**.

- When asked to enter hours of experience or supervision, you must calculate and enter an actual number of hours. Answers such as "40 hours/week" will not be accepted.

Both the applicant and supervisor(s) should carefully follow the instructions for completing the forms. ***Incomplete or incorrectly completed forms delay processing of your application*****. A resume will not be accepted in lieu of or in addition to the forms.**

Requirements for *All* Applications

☐ Submit completed, signed and notarized *Application for Licensed Associate Counselor of Mental Health*.
- Applications that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose the processing fee by check or money order made payable to the "State of Delaware."
- Applications not accompanied by the required fee will be rejected.

☐ Arrange for the Board office to receive verification of your examination scores and certification as follows:
- If you are certified by the National Board for Certified Counselors (NBCC) or the Academy of Clinical Mental Health Counselors (ACMHC), follow the instructions for requesting score verifications on the NBCC website at www.nbcc.org.
- If you are certified by another national mental health specialty, arrange for the Board office to receive a *National Certifying Organization Certification Form* sent *directly* from the certifying organization to the Board office. Follow the instructions on the form. Note that the organization must be acceptable to the Board. For more information on certifying organizations, see Section 2.1.1.1 of the Board's Rules and Regulations.

☐ Arrange for the Board office to receive a verification of licensure from each jurisdiction where you now hold, or have *ever* held, a license to practice as a mental health professional.
- You may use the *Verification of Licensure* form enclosed with this packet to request the verification.

☐ Arrange for the Board office to receive an official transcript showing your completed graduate degree, sent *directly* from the college/university to the Board office.

☐ If you have 30 post-Masters credit hours in the field of counseling, arrange for the Board office to receive an official transcript showing these graduate credits, sent *directly* from the school(s) to the Board office.

Requirements Related to *Completed* Experience

The following requirements document and verify how many hours of acceptable post-Masters experience in *mental health counseling* and hours of *direct supervision* you have already accrued.

☐ Arrange for the boxes entitled **COMPLETED DIRECT SUPERVISION** to be completed and signed by your **approved clinical supervisor(s)**.

- ***The total number of post-Master's direct supervision hours*** that you have provided must be clearly stated. Providing only the dates of your employment is not sufficient.
- If you had more than one period under different supervisors, have the approved clinical supervisor for each period complete a box for the period during which he or she supervised you.

☐ If you do not have 30 post-Master credit hours, arrange for the boxes entitled **COMPLETED PROFESSIONAL COUNSELING EXPERIENCE** to be completed and signed as indicated below. These boxes will verify the experience that you gained when you were not under the direct supervision of an approved clinical supervisor.

- For experience while you were employed, your *clinical or administrative supervisor(s)* must complete and sign the box.
- For experience while you were self-employed, a *professional colleague, supervisor or other individual who has personal knowledge of your professional practice while self-employed* must complete and sign the box. The person who attests to your experience while self-employed cannot be related to you as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.
- ***The total number of post-Master's mental health counseling hours*** that you have provided while not under direct supervision of an approved clinical supervisor must be clearly stated. Providing only the dates of your employment or self-employment is not sufficient.

Requirements Related to Written Plan for Professional Counseling Experience and Supervision

The following requirements document how many hours of post-Masters experience of *mental health counseling* and hours of *direct supervision* you still need to complete in order to meet the requirements for Delaware licensure as a Professional Counselor of Mental Health. Remember to add the planned hours to the completed hours to make sure that the totals meet the requirements for eventual licensure as a Professional Counselor of Mental Health.

☐ Arrange for the boxes entitled **Planned Direct Supervision** to be completed and signed by the *approved clinical supervisor(s)* under whose supervision you will complete the hours.

☐ If you do not have 30 post-Master credit hours, arrange for the boxes entitled **Planned Professional Counseling Experience** to be completed and signed to verify the experience that you plan to finish while not under the direct supervision of an approved clinical supervisor.

- For experience you plan to complete while employed, your *clinical or administrative supervisor(s)* must complete and sign the boxes.
- For experience you plan to complete while self-employed, a *professional colleague, supervisor or other individual who will have personal knowledge of your professional practice while self-employed* must complete and sign the boxes. The person who attests to your experience while self-employed cannot be related to you as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.

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BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

APPLICATION FOR LICENSED ASSOCIATE COUNSELOR OF MENTAL HEALTH

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last First Middle

2. Other Names Used: _____ _____ _____

3. Mailing Address: _____

   _____ _____ _____
   City State Zip

4. Phone: _____ _____ Email: _____
   Home Work

5. Date of Birth (month/day/year): _____

6. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
   - If yes, enter your SSN: _____
   - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

NATIONAL CERTIFICATION

7. Do you hold current certification from the NBCC, ACMHC or other national mental health specialty? Yes ☐ No ☐
   If yes, complete the following information about your certification(s):

Certifying Organization	Certification Number	Date Certified	Expiration Date
NBCC			
ACMHC			
Other: _____			

If you are certified by NBCC or ACMHC, arrange for the Board office to receive verification of your examination scores and certification sent *directly* from the organization. If you are certified by another national mental health specialty, arrange for the Board office to receive a *National Certifying Organization Certification Form* sent *directly* from the certifying organization to the Board office.

LICENSURE HISTORY – *All* applicants complete this section.

8. Have you ever held a license to practice as a mental health professional in any jurisdiction other than Delaware? Yes ☐ No ☐ If yes, enter the following information about *each* mental health license that you have *ever* held.

JURISDICTION	TYPE OF LICENSE HELD	LICENSE NUMBER	LICENSURE DATES	
			From	To

Arrange for the Board office to receive a verification of licensure from *each* jurisdiction where you have *ever* held a mental health professional license.

9. Have you ever been denied licensure in any other jurisdiction? Yes ☐ No ☐ If yes, explain fully: _____

_____

DISCLOSURES

10. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐ If yes, arrange for the Board office to receive a certified copy of your criminal history record.

11. Have you received any administrative penalties regarding your actions as a licensed, registered or certified mental health provider, including but not limited to fines, formal reprimands, license suspensions or revocation (except for license revocations for nonpayment of license renewal fees), probationary limitations, and/or have you entered into any "consent agreement" which contains conditions placed by a Board on your professional conduct, including any voluntary surrender of a license? Yes ☐ No ☐ If yes, attach a detailed explanation of all such penalties.

12. Are any disciplinary actions pending against you? Yes ☐ No ☐ If yes, attach a detailed explanation of any pending actions.

13. Have you done any of the following grounds for discipline?
    - committed or knowingly cooperated in a fraud or material deception in order to acquire a license
    - impersonated another person holding a license
    - allowed another person to use your license
    - aided or abetted an unlicensed person to represent himself or herself as a licensee?

    Yes ☐ No ☐ If yes, attach a detailed explanation of the violations.

14. Do you currently excessively use or abuse drugs or have you done so in the past 3 years? Yes ☐ No ☐ If yes, attach a detailed explanation.

15. Have you engaged in an act which involved consumer fraud or deception, restraint of competition, or price fixing? Yes ☐ No ☐ If yes, attach a detailed explanation.

16. Do you have any impairment related to drugs or alcohol or a finding of mental incompetence by a physician that would limit your ability to act as a professional counselor of mental health or associate counselor of mental health in a manner consistent with the safety of the public? Yes ☐ No ☐ If yes, attach a detailed explanation.

17. Have you been penalized for any willful violation of the code of ethics adopted by the Board, the NBCC code of ethics or other similar professional mental health counseling standard? Yes ☐ No ☐ If yes, attach a detailed explanation.

18. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? Yes ☐ No ☐ If yes, attach a detailed explanation of all such violations.

GRADUATE EDUCATION

19. Have you earned a Master's or higher post-graduate degree in a counseling or behavioral science field? Yes ☐ No ☐ If yes, enter this information about the program from which you received the highest degree.

    Highest Degree Received: _____ Degree Date: _____

    Institution Name: _____

    Address: _____ _____ _____ _____
    Street City State Zip

    Arrange for the Board office to receive an official transcript sent *directly* from the school to the Board office.

PROFESSIONAL CLINICAL EXPERIENCE

20. Do you have 30 post-Masters credit hours in the counseling field? Yes ☐ No ☐ If yes, complete the following information about your post-Masters credit hours:

    Educational Institution: _____

    Dates: _____ _____ Number of Credits Earned: _____
    From To

    Arrange for the Board office to receive an official transcript showing these graduate credits, sent *directly* from the school(s) to the Board office.

21. On the next pages, provide the requested information about the direct supervision and professional counseling experience that you have ***already completed***. Complete the boxes as follows:

    COMPLETED DIRECT SUPERVISION

    Arrange for your approved clinical supervisor to complete and sign the box entitled **COMPLETED DIRECT SUPERVISION** to verify the hours of direct supervision that you have already received. If you received direct supervision in more than one period under different supervisors, have the approved clinical supervisor for each period complete a box for the period during which he or she supervised you. Remember that…

    - The completed hours entered in Total Hours in this box(es) and the planned hours entered in the **Written Plan** (Question 22) must total at least the mandatory minimum 1600 hours of direct supervision.
      - The hours of completed face-to-face sessions entered here and the planned hours of face-to-face sessions entered in the **Written Plan** (Question 22) must total at least 100 hours.
      - The completed hours of one-on-one sessions you enter here and the planned hours of one-on-one sessions entered in the **Written Plan** (Question 22) must total at least 60 hours.
    - *All* of the required hours—completed plus planned whether or not directly supervised—must span a period of not less than two but no more than four years.

    COMPLETED PROFESSIONAL COUNSELING EXPERIENCE

    If you do <u>not</u> have 30 post-Masters credit hours in the counseling field, arrange for the box entitled **COMPLETED PROFESSIONAL COUNSELING EXPERIENCE** to be completed to verify the hours of post-Master's professional clinical counseling experience that you have already completed while <u>not</u> under the direct supervision of an approved clinical supervisor. Do <u>not</u> enter direct supervision hours in this box. Remember that…

    - If you completed hours in more than one period under different supervisors, complete a box for each period.
    - For experience while you were employed, your clinical or administrative supervisor(s) must complete and sign the box. For experience while self-employed, a professional colleague, supervisor or other individual who has personal knowledge of your professional practice while self-employed must complete and sign the box. The person who attests to your experience while self-employed cannot be related to you as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.
    - When *all* hours are added together, your planned and completed hours of direct supervision plus your completed and planned hours of professional counseling experience must total 3200 hours.
    - *All* of the completed and planned hours—whether or not direct supervision—must span a period of not less than two but no more than four years.

If you need more boxes for additional periods, you may copy this page.

COMPLETED DIRECT SUPERVISION

Enter only hours completed while under the direct supervision of an approved clinical supervisor.

Note: Direct supervision is overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment. Individual direct supervision is face-to-face, one-on-one (just you and your supervisor). Group direct supervision is face-to-face between you, your supervisor and up to five other supervisees.

INFORMATION ABOUT CLINICAL SUPERVISOR

1. Supervisor Name: _____ _____ _____
   Last First Middle

2. Provide the following information about your professional licensure:

✓	LICENSES HELD (check all that apply)	STATE	LICENSE #	ISSUE DATE
☐	Professional Counselor of Mental Health			
☐	Clinical Social Worker			
☐	Marriage and Family Therapist			
☐	Clinical Psychologist			
☐	Psychiatrist			

3. Supervisor's Practice Name (if applicable): _____

4. Practice Address: _____

   _____ _____ _____
   City State Zip

5. Phone: _____ Email: _____

DIRECT SUPERVISION HOURS

6. Did you provide ***direct supervision,*** as defined above, to the applicant? Yes ☐ No ☐ If no, skip to the **Signature**.

7. Enter the dates of post-Master's clinical experience that the applicant provided while under your direct supervision:

   From _____ To _____ ***Alert:*** ***This period must not span more than four years.***
   Month/Year Month/Year

8. Calculate and enter the total number of hours of mental health counseling that the applicant provided while under your direct supervision during this period: _____ ***Alert:*** ***Answers such as "40 hours/week" will not be accepted.***

9. During this period, how many total hours of face-to-face, individual (one-on-one) supervision did you provide to the applicant? _____

10. During this period, how many total hours of face-to-face, group supervision did you provide to the applicant? _____

CERTIFICATION

I certify that I have personally completed this information and that the information provided herein is accurate and complete to the best of my knowledge.

Clinical Supervisor Signature: _____ Date: _____

If you need more boxes for additional periods, you may copy this page.

COMPLETED PROFESSIONAL COUNSELING EXPERIENCE

Enter only hours completed while <u>not</u> under the direct supervision of an approved clinical supervisor.

INFORMATION ABOUT PERSON VERIFYING EXPERIENCE

1. Name: _____ _____ _____
   Last First Middle
2. Practice Name Where Experience Occurred: _____
3. Practice Address: _____

   _____ _____ _____
   City State Zip
4. Phone: _____ Email: _____
5. Are (or were) you the applicant's supervisor? Yes ☐ No ☐
   - If yes, check type of supervisor: ☐ Clinical ☐ Administrative
   - If no, explain your relationship to the applicant: _____

EXPERIENCE HOURS

6. Enter the period when you supervised the applicant. (If you were not his or her supervisor, enter the period about which you have personal knowledge of the applicant's practice while self-employed.)

   From _____ To _____ ***<u>Alert</u>: This period must not span more than four years.***
   Month/Year Month/Year
7. During this period, the applicant was: ☐ Employed—Position: _____
   ☐ Self-Employed—Title: _____
8. Calculate and enter the total number of hours of mental health counseling that the applicant provided during this period while <u>not</u> under direct supervision of an approved supervisor: _____ ***<u>Alert</u>: Answers such as "40 hours/week" will <u>not</u> be accepted.***
9. Describe the practice, agency, or setting where the applicant worked during the period above. (Examples include group practice, community mental health agency, elementary school, etc.)

   _____

   _____

CERTIFICATION

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

22. On the next pages, provide the requested information about the hours of direct supervision and professional counseling that ***you plan to provide*** while not under direct supervision of an approved clinical supervisor. These pages constitute your **Written Plan for Professional Counseling Experience and Supervision**. Complete the boxes as follows:

Planned Direct Supervision

Arrange for your approved clinical supervisor to complete and sign the box entitled **Planned Direct Supervision** to verify the hours of direct supervision that you will complete under his or her supervision. If you will receive direct supervision in more than one period under different supervisors, have the approved clinical supervisor for each period complete a box for the period during which he or she will supervise you. Remember that…

- The completed hours in Question 21 and the planned hours in the **Written Plan** must total at least the mandatory minimum 1600 hours of direct supervision.
  - The hours of completed face-to-face sessions in Question 21 and the planned hours of face-to-face sessions in the **Written Plan** must total at least 100 hours.
  - The completed hours of one-on-one sessions in Question 21 and the planned hours of one-on-one sessions in the **Written Plan** must total at least 60 hours.
- ***All*** completed hours in Question 21 and planned hours in the **Written Plan** must span a period of at least two but not more than four years.

Planned Professional Counseling Experience

If you do not have 30 post-Masters credit hours in the counseling field, arrange for the box entitled **Planned Professional Counseling Experience** to be completed to verify the hours of post-Master's professional clinical counseling experience that you will complete while not under the direct supervision of an approved clinical supervisor. Do not enter planned direct supervision hours in this box. Remember that…

- If you will complete hours in more than one period under different supervisors, complete a box for each period.
- For planned experience while employed, your clinical or administrative supervisor(s) must complete and sign the box. For planned experience while self-employed, a professional colleague, supervisor or other individual who has personal knowledge of your professional practice while self-employed must complete and sign the box. The person who attests to your experience while self-employed cannot be related to you as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.
- When *all* hours are added together, your planned and completed hours of direct supervision plus your completed and planned hours of professional counseling experience must total 3200 hours.
- *All* of the completed and planned hours—whether or not direct supervision—must span a period of not less than two but no more than four years.

WRITTEN PLAN FOR PROFESSIONAL COUNSELING EXPERIENCE AND SUPERVISION

If you need more boxes for additional periods, you may copy this page.

Planned Direct Supervision

Enter only hours that will be completed while under the direct supervision of an approved clinical supervisor.

Note: Direct supervision is overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment. Individual direct supervision is face-to-face, one-on-one (just you and your supervisor). Group direct supervision is face-to-face between you, your supervisor and up to five other supervisees.

INFORMATION ABOUT CLINICAL SUPERVISOR

1. Supervisor Name: _____ _____ _____
   Last First Middle

2. Provide the following information about your professional licensure:

✓	LICENSES HELD (check all that apply)	STATE	LICENSE #	ISSUE DATE
☐	Professional Counselor of Mental Health			
☐	Clinical Social Worker			
☐	Marriage and Family Therapist			
☐	Clinical Psychologist			
☐	Psychiatrist			

3. Supervisor's Practice Name (if applicable): _____

4. Practice Address: _____

   _____ _____ _____
   City State Zip

5. Phone: _____ Email: _____

DIRECT SUPERVISION HOURS

6. Will you provide ***direct supervision,*** as defined above, to the applicant? Yes ☐ No ☐ If no, skip to the **Signature**.

7. Enter the dates of planned post-Master's clinical experience that the applicant will provide while under your direct supervision:

   From _____ To _____ ***Alert: This period must not span more than four years.***
   Month/Year Month/Year

8. Calculate and enter the total number of hours of mental health counseling that the applicant will provide during this period while under your direct supervision: _____ ***Alert: Answers such as "40 hours/week" will not be accepted.***

9. During this period, how many total hours of face-to-face, individual (one-on-one) supervision will you provide to the applicant? _____

10. During this period, how many total hours of face-to-face, group supervision will you provide to the applicant? _____

CERTIFICATION

I certify that I have personally completed this information and that the information provided herein is accurate and complete to the best of my knowledge.

Clinical Supervisor Signature: _____ Date: _____

WRITTEN PLAN FOR PROFESSIONAL COUNSELING EXPERIENCE AND SUPERVISION

If you need more boxes for additional periods, you may copy this page.

Planned Professional Counseling Experience

Enter only hours that will be completed while <u>not</u> under the direct supervision of an approved clinical supervisor.

INFORMATION ABOUT PERSON VERIFYING EXPERIENCE

1. Name: _____ _____ _____
   Last First Middle
2. Practice Name Where Experience Will Occur: _____
3. Practice Address: _____

   _____ _____ _____
   City State Zip
4. Phone: _____ Email: _____
5. Are you the applicant's supervisor? Yes ☐ No ☐
   - If yes, check type of supervisor: ☐ Clinical ☐ Administrative
   - If no, explain your relationship to the applicant: _____

EXPERIENCE HOURS

6. Enter the period when you will supervise the applicant. (If you are not his or her supervisor, enter the period about which you will have personal knowledge of the applicant's practice while he or she is self-employed.)

   From _____ To _____ ***<u>Alert</u>: This period must not span more than four years.***
   Month/Year Month/Year
7. During this period, the applicant will be: ☐ Employed—Position: _____
   ☐ Self-Employed—Title: _____
8. Calculate and enter the total number of hours of mental health counseling that the applicant will provide during this period while <u>not</u> under direct supervision of an approved supervisor: _____ ***<u>Alert</u>: Answers such as "40 hours/week" will <u>not</u> be accepted.***
9. Describe the practice, agency, or setting where the applicant will work during the period above. (Examples include group practice, community mental health agency, elementary school, etc.)

   _____

   _____

CERTIFICATION

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded.

Please note: When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

The undersigned applicant for Licensed Associate Counselor of Mental Health, being sworn, deposes and affirms that he or she is the person who executed this application; that the statements contained on this application are true in every respect; that he or she has not suppressed or withheld information that might affect this application; that he or she will abide by the laws and the ethical standards of this profession; and that he or she has read and understands this statement.

The applicant further affirms that he or she has read and understands the Written Plan for Professional Counseling and Supervision contained in the application and that he or she will promptly report any change in the plan to the Board office.

The applicant authorizes all jurisdictions to release any and all information regarding his/her disciplinary history and current status to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant: _____ Date: _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____2_____.

Signature of Notary: _____

SEAL

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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DEPARTMENT OF STATE
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FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

VERIFICATION OF LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice as a mental health practitioner. Before sending this form to the jurisdiction, it is advisable to find out if the jurisdiction requires a fee to provide a license verification. You may duplicate this form.

This section to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ Date of Birth:_____ Other Name(s) Used: _____ Jurisdiction Where LIcensed: _____ License/Registration Number(s) in Jurisdiction Named Above: _____ I am applying for Delaware licensure as a: ☐ Professional Counselor of Mental Health ☐ Associate Counselor of Mental Health ☐ Chemical Dependency Professional ☐ Marriage and Family Therapist ☐ Associate Marriage and Family Therapist Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Mental Health and Chemical Dependency Professionals. **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority.	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of: _____ as a (type of license) _____ Registration/License Number: _____ Issue Date (mm/dd/yyyy): _____ Expiration Date (mm/dd/yyyy): _____ Has the licensee ever been subject to any disciplinary action or had his/her license revoked or suspended? Yes ☐ No ☐ **If yes, please enclose a certified copy of the board's final order with this license verification.** Are any disciplinary proceedings or unresolved complaints pending against the licensee? Yes ☐ No ☐
AFFIX OFFICIAL SEAL HERE	***I certify that the statements contained herein are true and correct.*** Printed Name of Official: _____ Signature of Official: _____ Date: _____ Title:_____ Phone: _____ Fax: _____ Email:_____

Return completed, signed and sealed form *directly* to the Board office at the address above.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

CERTIFYING ORGANIZATION CERTIFICATION FORM

The applicant below has applied for Delaware licensure as a mental health professional. This form elicits information about the applicant's certification issued by a national mental health specialty *other than* the National Board for Certified Counselors or the Academy of Clinical Mental Health Counselors.

INFORMATION ABOUT APPLICANT – Applicant completes this section and sends to certifying organization.

1. Full Name: _____ _____ _____
   Last First Middle
2. Mailing Address: _____

   _____ _____ _____
   City State Zip
3. Phone: _____ _____ Email: _____
   Home Work
4. Certifying Organization Name: _____

   Certified as: _____ Certification No. _____

   Date Certified: _____ Expiration Date: _____

I hereby authorize the certifying agency named above to release information regarding my certification to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Applicant Signature: _____ Date:_____

INFORMATION ABOUT CERTIFYING ORGANIZATION – Official of certifying organization completes this section and mails *directly* to the Board office at the address in the letterhead.

1. Name of Certifying Organization: _____
2. Address: _____

   _____ _____ _____
   City State Zip
3. Is the applicant currently certified as represented above? Yes ☐ No ☐
4. Is the applicant currently in good standing? Yes ☐ No ☐ If no, please explain: _____

   _____
5. To enable the Delaware Board to evaluate the applicant's certification, please enclose the following documents:

   ☐ Statement of Mission and Scope of Membership
   ☐ Membership Requirements
   ☐ Description of Membership Examination
   ☐ Code of Ethics for Members

Signature of Official: _____ Date: _____

Printed Name of Official: _____ Title: _____